BOISE DENTISTRY CO.

FAMILY DENTISTRY & WELLNESS

HEALTH HISTORY

First Name _____ Middle _____ Last Name _____

Date of Birth _____ Social Security # _____ Sex ____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Emergency Contact (Full Name) _____ Emergency Contact Phone _____

Employer _____ Occupation _____ Work Phone _____

Please tell us why you are here today: _____

_____

Whom may we thank for your referral? _____

Medical History

YES

Are you taking natural blood thinners (fish oil, omega 3, etc)? ☐

Are you taking prescription blood thinners (apixaban, dabigatran, aspirin, etc) ☐

Has a physician told you to take antibiotics prior to a dental procedure (Premedication / Antibiotic prophylaxis)? ☐

Are you currently under the care of a physician/specialist? (Please list) _____

_____

Are you taking natural remedies, vitamins, over-the-counter medications? _____

Are you being seen for pain management? (List current doctor) _____

Any physical disabilities/deformities (Please describe) _____

_____

Known medication side effects? (Please describe) _____

_____

Please list ALL medications you're currently taking (Name, Dosage, and Frequency) _____

_____

_____

Hospital/Surgery History

Any complications due to surgical/medical care? (Please describe) _____

_____

Complication(s) with sedation/anesthesia? (Please describe) _____

_____

CANCER (CURRENTLY HAVE)

YES		YES		YES	
☐	Brain	☐	Leukemia	☐	Skin
☐	Breast	☐	Lung	☐	Thyroid
☐	Esophagus	☐	Lymphoma	☐	Tongue
☐	Kidney	☐	Oral Cavity, Lip, or Floor of Mouth		
☐	Receiving Chemotherapy	☐	Receiving Radiation		

☐ Other (please describe) _____

_____

CANCER (PREVIOUSLY DIAGNOSED)

YES

- ☐ Brain
- ☐ Breast
- ☐ Esophagus
- ☐ Kidney
- ☐ Receiving Chemotherapy
- ☐ Other (please describe) _____

YES

- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Oral Cavity, Lip, or Floor of Mouth
- ☐ Receiving Radiation

YES

- ☐ Skin
- ☐ Thyroid
- ☐ Tongue

HEPATITIS

YES

- ☐ A
- ☐ B
- ☐ C

PERSONAL HISTORY

YES

- ☐ Arthritis
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Mental and Behavioral Disorders
- ☐ Osteoporosis (Age Related)
- ☐ Osteoporosis (Drug Related)
- ☐ PTSD (Post-Traumatic Stress Disorder)
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sjogren's Syndrome
- ☐ Trigeminal Neuralgia (Facial Nerve Pain)
- ☐ Tuberculosis

ALLERGIES

YES

- ☐ Aspirin
- ☐ Acrylic
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin/Amoxicillin
- ☐ Seasonal Allergies
- ☐ Sulfa Drugs
- ☐ Other Allergies Not Mentioned (list below):

_____

_____

BLOOD-RELATED CONDITIONS

YES

- ☐ Anemic
- ☐ Bruises Easily
- ☐ Conditions of Spleen
- ☐ Increased Risk of Bleeding

INJURY/TRAUMA TO FACE/MOUTH

YES

- ☐ Face
- ☐ Head
- ☐ Lip
- ☐ Mouth (Oral Cavity)

MOUTH

YES

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Canker Sores
- ☐ Difficulty Controlling Mouth, Lip, and Tongue to Control Food/Liquid
- ☐ Difficulty Swallowing
- ☐ Excessive Thirst

DRY MOUTH

YES

- ☐ Substitute Treatment Attempted: Sugar-Free Gum, Sip Water, or Saliva

DO YOU GET HEADACHES OR MIGRAINES?

YES

- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Tension Headaches

PAIN WHEN CHEWING

YES

- ☐ Left Side
- ☐ Right Side
- ☐ Both Sides

TYPE 1 DIABETIC

YES

- ☐ Controlled
- ☐ Uncontrolled Low Blood Sugar (Hypo)
- ☐ Uncontrolled High Blood Sugar (Hyper)
- ☐ Insulin Dependent
- ☐ Taking Insulin

TYPE 2 DIABETIC

YES

- ☐ Controlled
- ☐ Uncontrolled Low Blood Sugar (Hypo)
- ☐ Uncontrolled High Blood Sugar (Hyper)
- ☐ Insulin Dependent
- ☐ Taking Insulin

INTESTINAL AND DIGESTIVE

YES

- ☐ Acid Reflux
- ☐ GERD
- ☐ History of Anorexia Nervosa
- ☐ History of Bulimia Nervosa
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Stomach Ulcers

TOBACCO USE

YES

- ☐ Currently use Tobacco (cigarettes, cigars, vapes, smokeless tobacco)
- ☐ Not currently using Tobacco but have a history of using cigarettes, cigars, vapes, or smokeless tobacco

DRUGS (CURRENT OR HISTORICAL)

YES

- ☐ Alcohol Abuse (Current or Historical)
- ☐ Cocaine
- ☐ Ecstasy/PCP
- ☐ Heroin
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Opioids
- ☐ Other (please list)

_____

_____

STROKE/BELL'S PALSY

YES

- ☐ Bell's Palsy
- ☐ Facial Weakness
- ☐ Left Side Weakness (Left Hand Dominant)
- ☐ Left Side Weakness (Right Hand Dominant)
- ☐ Right Side Weakness (Left Hand Dominant)
- ☐ Right Side Weakness (Right Hand Dominant)

HEART CONDITIONS

YES

- ☐ Artificial Heart Valves
- ☐ COPD (Constructive Obstructive Pulmonary Disease)
- ☐ Frequently Experience Light Headedness/Dizziness
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Chest Pain/Pressure
- ☐ History of Heart Attack
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Shortness of Breath
- ☐ Swelling of the Ankles
- ☐ Have you ever been told you have a Heart Murmur?
- ☐ Taken Fen Phen or Redux?
- ☐ If so, have you had your heart examined by a Physician, and when?

_____

_____

THYROID CONDITIONS

YES

- ☐ Cyst on Thyroid
- ☐ Enlarged Thyroid
- ☐ Hyperthyroid
- ☐ Hypothyroid

EYE/EAR/NOSE/THROAT

YES

- ☐ Blurry Vision
- ☐ Broken Nose
- ☐ Clogged Sinuses
- ☐ Deviated Septum
- ☐ Frequent Sinus Infections
- ☐ Nasal Congestion
- ☐ Trouble Breathing Through Your Nose

RINGING IN EARS

YES

- ☐ Left
- ☐ Right
- ☐ Both

PAIN IN YOUR EARS

YES

- ☐ Left
- ☐ Right
- ☐ Both

HEARING LOSS

YES

- ☐ Left
- ☐ Right
- ☐ Both

RESPIRATORY CONDITIONS

YES

- ☐ Asthma
- ☐ Chronic Coughing
- ☐ COPD
- ☐ Fainting Spells
- ☐ History of Bronchitis
- ☐ Lung Disease

SLEEP RELATED CONDITIONS

YES

- ☐ CPAP – Goes Without Using Regularly Uses CPAP
- ☐ Do You Mouth Breathe?
- ☐ History of Narcolepsy
- ☐ History of Thumb Sucking
- ☐ Insomnia
- ☐ Sleep Apnea
- ☐ Sleep Study Performed
- ☐ Snoring

JAW AND JOINT

YES

- ☐ Dislocated Jaw Paint (History of)
- ☐ Grind Your Teeth
- ☐ Muscle Spasms
- ☐ Pain Upon Awakening

PAIN UPON OPENING MOUTH

YES

- ☐ Left Side
- ☐ Right Side
- ☐ Both Sides

JAW PAIN

YES

- ☐ Left Side
- ☐ Right Side
- ☐ Both Sides

CLICKING OR POPPING OF JAW JOINT

YES

- ☐ Left Side
- ☐ Right Side
- ☐ Both Sides

DISLOCATED JAW (CURRENT)

YES

- ☐ Left Side
- ☐ Right Side
- ☐ Both Sides

SWELLING IN JAW

YES

- ☐ Left Side
- ☐ Right Side
- ☐ Both Sides

FEMALES ONLY

YES

- ☐ Nursing or Pumping
- ☐ Pregnant or Trying to Get Pregnant
- ☐ Reached Menopause
- ☐ Taking Contraceptives or Other Hormones
- ☐ Taking Bisphosphonates (aka Bonita, Fosamax, Actonel)

Medical Release

Without specific permission, we **WILL NOT** release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (spouse, child, mother, etc). We will, however, release information to another doctor to aid in your care.

Name _____ Relation _____

_____ _____

Consents

I attest that I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of changes in my health, my health history, and/or medication. I certify that I consent to taking x-rays and an oral examination. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I understand that my dentist will explain the purpose of the services and that I have the right to refuse any recommended services.

_____ **(Initial Here)**

I authorize the release of all medical information necessary to process my claims and for the purpose of payment, treatment, and operations. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I assign the benefits payable for services to the dentist furnishing the services, and that I am financially responsible for payment in full of all accounts. I authorize release of my protected health information, when necessary, to other providers rendering medical/dental care, for pharmaceutical purposes, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

_____ **(Initial Here)**

This authorization will remain in effect until revoked by me in writing. A photocopy of my authorizations is to be considered as valid as the original.

_____ **(Initial Here)**

_____ _____ _____

Signature of Patient or Legal Guardian | Print Name | Dated

4266 N. Eagle Rd., Boise ID 83713 208.939.7053 office@boisedentistryco.com

BOISE DENTISTRY CO.

FAMILY DENTISTRY & WELLNESS

MEDICAL RELEASE

Name: _____

_____

_____

_____

_____

Release: _____

_____

_____

_____

_____

Important: *You assume responsibility to notify the office of phone number(s) changes or changes to the individuals that you wish to share your medical information with.*

Consents

By selecting 'Yes', I attest that I have answered every question completely and accurately to the best of my knowledge. I will inform my doctor of any changes in my health, my health history, and/or medication. I certify that I consent to taking x-rays and an oral examination. I consent to the diagnostic procedures and treatment by the doctor necessary for proper oral care. I understand that my doctor will explain the purpose of any recommended services and that I have the right to refuse any recommended services.

_____ **(Initial Here)**

By selecting 'Yes', I authorize the release of all medical information necessary to process my claims and for the purpose of payment, treatment, and operations. I authorize payment directly to the doctor of insurance benefits otherwise payable to me. I assign the benefits payable for services to the doctor furnishing the services. In consideration of services, I agree and understand that my insurance may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I authorize release of my protected health information, when necessary, to other providers rendering health care, for pharmaceutical purposes, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

_____ **(Initial Here)**

By selecting 'Yes', this authorization will remain in effect until revoked by me in writing. A photocopy of my authorizations is to be considered as valid as the original.

_____ **(Initial Here)**

By selecting 'Yes', I agree to receive text messages from Boise Dentistry Co. Standard message and data rates apply.

_____ **(Initial Here)**

_____	_____	_____
Signature of Patient or Legal Guardian	Print Name	Dated